Assessment & Treatment of Mentally Ill AODA Clients II. Anxiety Disorders [Panic, Social Phobia, Agoraphobia, OCD

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Goals

- Understand prevalence of anxiety disorders in people with substance use disorders [SUDs]
- Diagnostic Criteria, Possible Mechanisms, and Assessment Strategies
- Natural History of Anxiety Disorders & Relationship to Substance Use
- Treatment Issues
- System Issues

PREVALENCE OFANXIETY DISORDERS:

Lifetime, Past Year, and in People with Alcohol or Drug Use Disorder

Disorder	1 yr (%)	Life (%)	SUD pts (%)
Social Phobia	7.9	13.3	3-28
Agoraphobia w/o PD	2.8	5.3	2-12
Panic Disorder	2.3	3.5	3-4
PTSD		8.2	14-36
OCD		3.0	3-11
GAD	3.1	5.1	10

Kessler et al. Arch Gen Psychiatry 1994; Schuckit et al., 1997; Compton et al. Am J Addict 2000

Substantial Under-Recognition

and

Substantial Under-Treatment

ANXIETY DISORDERS

PANIC DISORDER

AGORAPHOBIA

SOCIAL PHOBIA

OBSESSIVE-COMPULSIVE DISORDER

POST TRAUMATIC STRESS DISORDER

GENERALIZED ANXIETY DISORDER

90% of recently abstinent substance abusers report anxious mood in the past week

Most remit spontaneously

PANIC DISORDER
AGORAPHOBIA

Symptoms of Panic Attacks

Discrete period of intense fear or discomfort in which ≥ 4 of the following develop and peak within 10 min.

- hot flushes
- trembling or shaking
- palpitations, pounding heart, or accelerated HR
- abdominal distress or nausea
- numbness or paresthesia
- increased sweating
- chest pain or discomfort
- dizziness, unsteady, lightheaded, or faintness
- derealization or depersonalization
- dyspnea or smothering
- fear of dying
- feeling of choking
- fear of losing control or going crazy

HOT PANIC DID DYING
CHILL

APA, DSM-IV, 1994

Lifetime Prevalence of Panic Phenomenology

Fearful Spells:
15.6%

Panic Attacks:
7.3%

Panic Disorder:
4.2%

Eaton et al. Am J Psychiatry. 1994;151:414

Symptoms of Agoraphobia

A. Anxiety about being in places or situations fom which escape might be difficult or embarassing, or in which help might not be available if panic sxs or attack occur

B. Situations are avoided [e.g., travel restricted] or endured with marked distress or anxiety about having panic sxs, or require companion accompaniment.

C. Anxiety or phobic avoidance not better accounted for by another disorder, e.g, Social Phobia, Specific Phobia, OCD, PTSD, or Separation Anxiety Disorder.

APA, DSM-IV, 1994

Cognitive-Behavioral Model of Panic Disorder

Genetics*, CO_2, caffeine, hormones*, stressors

↓

Spontaneous Panic Attacks

↓

Repeated Spontaneous and Precipitated Panic Attacks

↓

Anticipatory Anxiety

↓

Avoidance Behavior*

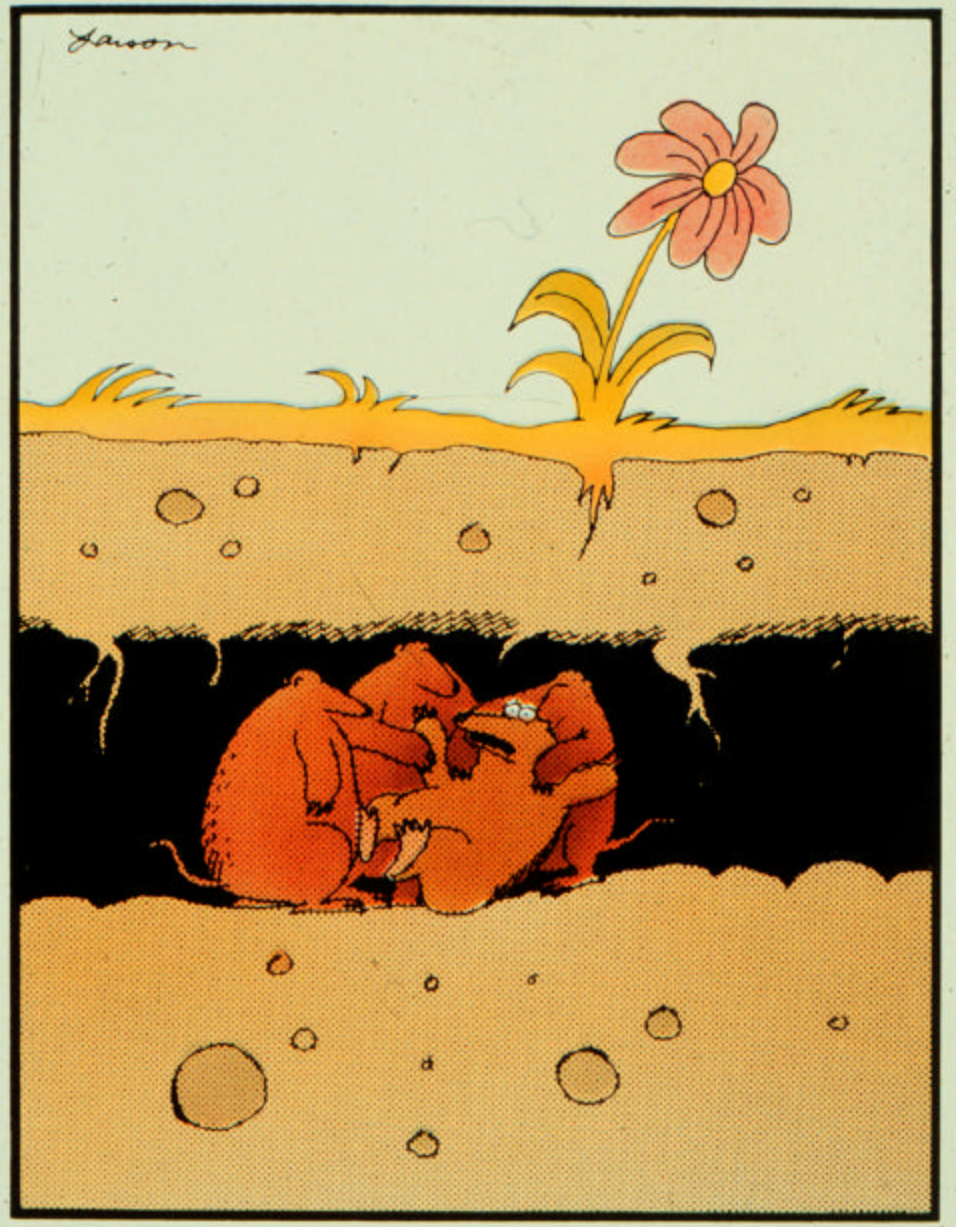
↓

Agoraphobia

*partly shared with alcoholism

*F>M

Kendler et al. 1995; Merikangas et al., 1996



"It's OK! It's OK! The tunnel was closing in on me there for a while, but I'm all right now."

Panic Disorder: DSM-IV Classification

- **Recurrent unexpected** panic attacks
- At least 1 of the attacks has been followed by 1 or more of the following for at least 1 month
  - Persistent concern about having additional attacks
  - Worry about the implications of the attack
  - A significant change in behavior

American Psychiatric Association. DSM-IV, 1994. p. 397

Epidemiology and Course of Panic Disorder

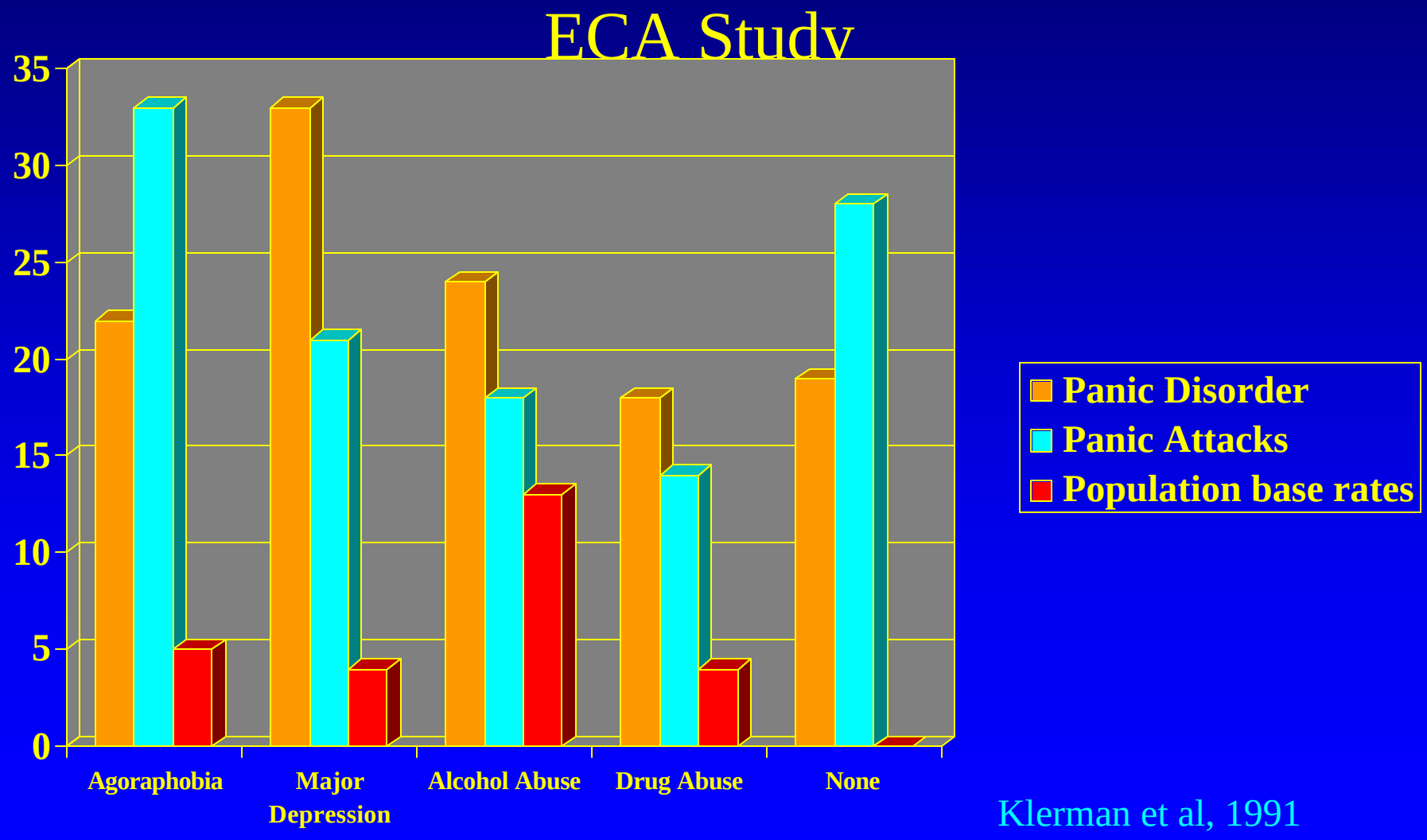
- Onset age 28 ± 11 yrs; female 2x men
- Agoraphobia in 75% M and 85% F
- 44% M and 23% F have lifetime alcohol abuse, but alcohol does not affect onset or recurrences
- 39% remit by 5 years in M and F
- Few remissions after 3 years
- Recurrences among remitted pts high: at 3 yr among PD pts, 65% of F and 39% of M recurred; among PD w/ AGOR pts, 75% of F and 47% of M had a recurence.

Complications of Panic Disorder

- **Increased comorbidity**
- **Chronic unemployment, absenteeism 2-3X higher, 25% on disability, 44% lower productivity; impaired social and marital function**
- **Increased utilization of medical services**
- **Premature mortality**
  - **-Suicide**
  - **-Cardiovascular; cardiac fatality 2-3X higher**

More agoraphobia and comorbidity in women

Comorbidity in Panic Disorder and Panic Attacks



Klerman et al, 1991

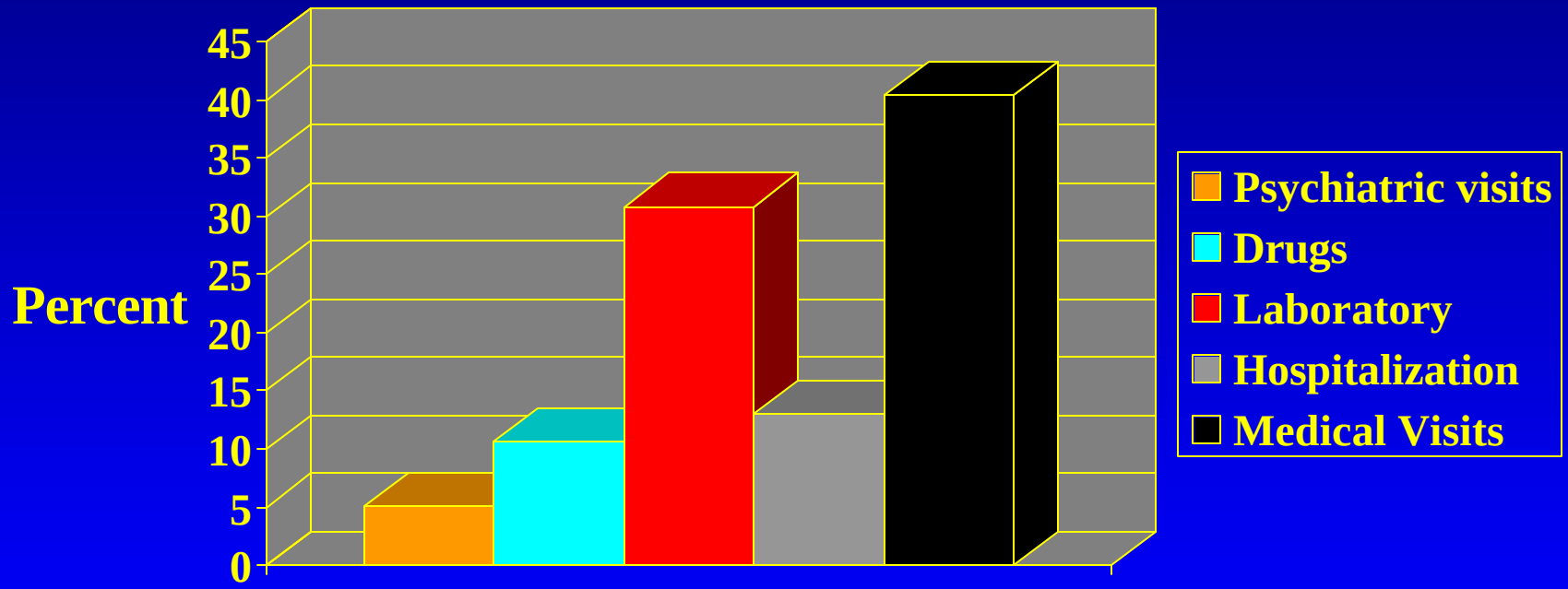
Health Care Utilization in Panic Disorder

Patients with panic disorder use medical treatment facilities seven times more frequently than the general population

Conner, Davidson. In: *Panic Disorder and its Treatment*
Rosenbaum, Pollack eds. NY: Marcel Dekker; 1998:269-322.

Direct Costs Distribution

Undiagnosed Panic Disorder

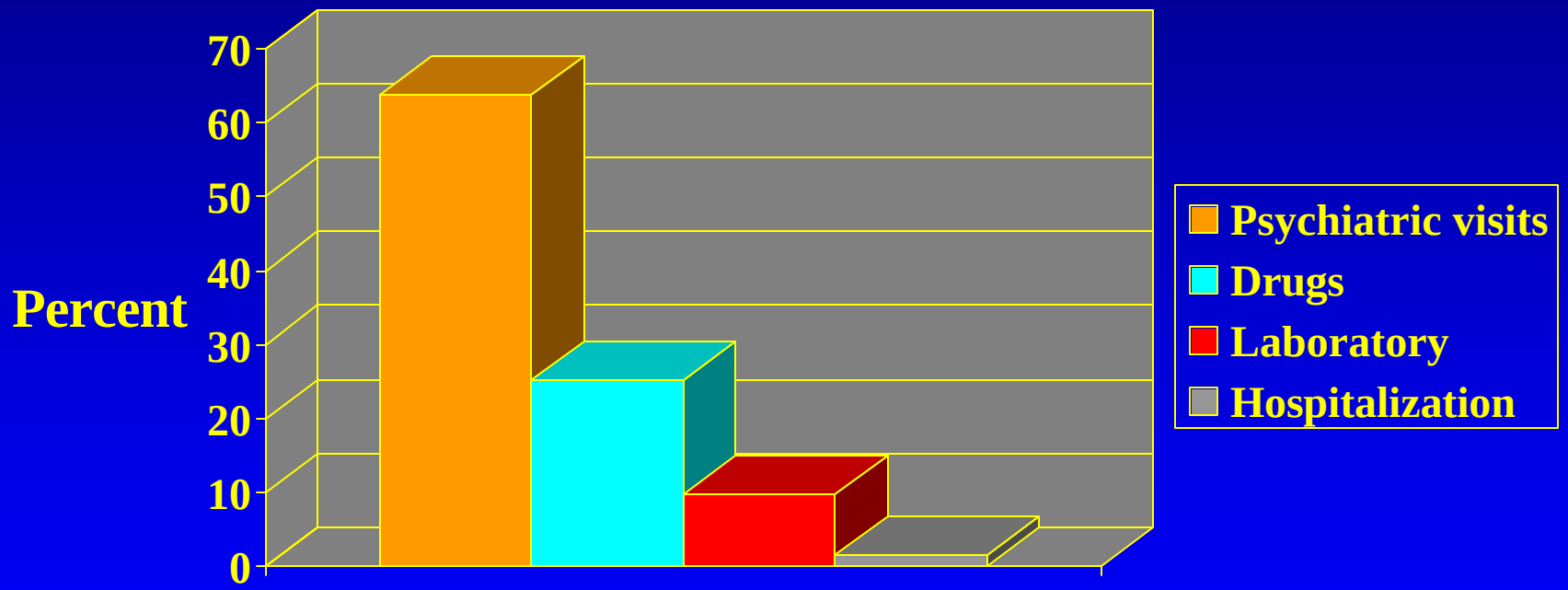


Direct costs distribution in 61 patients with panic disorder before (period I) and after diagnosis (period II). (Alternative medicine is not included.)

Salvador-Carulla L et al. Br J Psychiatry Suppl. 1995;166(27):23-28

Direct Costs Distribution

Diagnosed Panic Disorder



Direct costs distribution in 61 patients with panic disorder before (period I) and after diagnosis (period II). (Alternative medicine is not included.)

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Quality of Life and Panic Disorder

Primary care studies show:

Panic disorder patients have more mental health and role function problems than patients with hypertension, diabetes, and heart disease, but less disability than depression

Shearborne CD et al. Am J Psychiatry. 1996;153:213-218.

SUDs and Panic Disorder

Studies show

- **Agoraphobia is risk factor for SUDs**
- **Panic Disorder is NOT a risk factor for SUDs, but usually begins after onset of SUD**
- **Only 10% of PD pts in primary care reported using alcohol and 6% illicit drugs to treat their panic.**
- **Alcohol pretreatment reduces strictly defined panic attacks induced by CO2**

Kushner et al. Arch Gen Psychiatry 1996 Mar;53(3):264-70; Katerndahl and Realini Addict Behav 1999

Clinical Treatment of Concurrent Panic Disorder and SUDs

- **Establish abstinence: many alc/sed withdrawal and stimulant use sxs difficult to distinguish from panic**
- **Rule out other causes: illnesses [thyroid, epilepsy, hypoglycemia, cardiac, pheo] and caffeine**
- **Avoid Caffeine**
- **Cognitive Behavioral and Interpersonal Psychotherapy may be helpful: one negative trial on inpatients**

Bowen RC et al. Addict Behav 2000 Jul-Aug;25(4):593-7

Cognitive Behavioral Therapy for Panic and Agoraphobia

- Robust and effect treatment for panic, and particularly for agoraphobic avoidance, with good durability of effect in non-SUD pts
- Exposure treatment overcomes avoidant behavior, allowing deconditioning; however, may not eliminate spontaneous panic attacks or prevent some relapses
- May be used to reduce withdrawal symptoms while tapering benzodiazepines

Manual: D. Beckfield *Master Your Panic, 2e*

Spiegel and Bruce, Am J Psychiatry 1997

Clinical Trials: CBT of Panic and Agoraphobia in SUD Pts.

- One study in SUD pts. All inpatients. No difference in wait list and CBT treatment groups. No Rx given.

- Problems: high ambient anxiety, little cue exposure, primary/secondary dx, short-term follow-up interval

Bowen RC et al. Addict Behav 2000 Jul-Aug;25(4):593-7

Panic Disorder and Caffeine

The Clinical Significance of Co-Occurring Caffeine Intoxication and Panic Disorder

- > 50% of panic disorder pts have panic sxs after caffeine infusion [300 mg]
- caffeine use associated with increased frequency of PAss
- caffeine abstinence reduces frequency of PAs
- Need to take careful caffeine hx

Panic Disorder Rx in SUD Patients

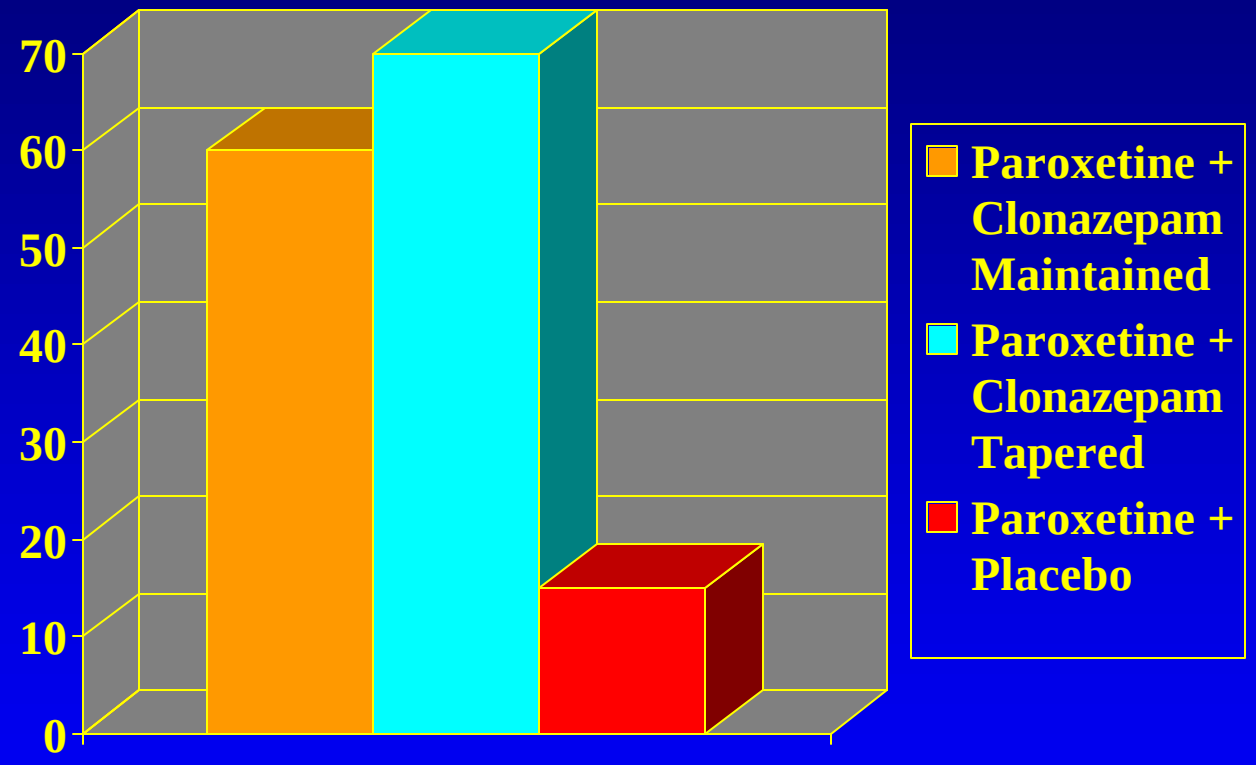
- SSRIs:
- Tricyclic Antidepressants
- MAO Inhibitors
- Gabapentin
- Benzodiazepines: clonazepam [1-2mg as effective as 4mg qd in non-SUD pts]; alprazolam

Rosenbaum et al. J Clin Psychopharm 1997

Antidepressant Side Effects Relevant in Substance Abuse Treatment

Side Effects	Drug Class	Issue
Tremors	SSRIs, TCAs	may mimic w'drawal
Nausea	SSRIs	"
Headaches	SSRIs	", cause pain
Seizures	TCAs	w/drawal Sz, Eat D/o
Loss Libido	SSRIs, TCAs	noncompliance
Hypertension	MAOIs w/tryptamine	CVA
Hypotension	MAOIs, TCAs	risk falls
Mydriasis	TCAs	mimic withdrawal
Sedation	TCAs, Paxil	increase w/EtOH

Combined Treatment for Panic Disorder



Responder status = CGI 1 or 2 and 0 panic attacks

N=19; p<.09

Simon et al, 1998

Outcome of Panic Disorders at Long-Term (> 1-year) Follow-Up

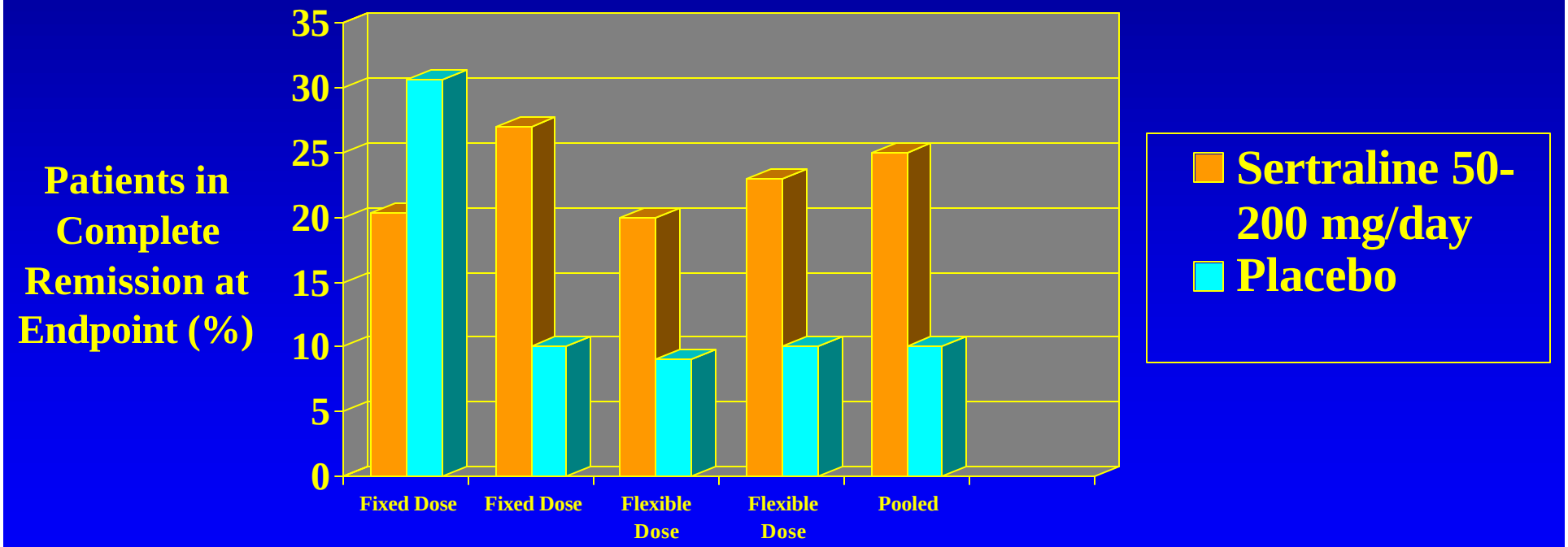
		Persistence
	Mean Rate (%)	Range (%)
Panic Attacks (*n=15)	46	17-70
Phobic Avoidance (n=7)	69	36-82
Functional Impairment (n=5)	50	39-67

*n=number of controlled acute treatment plus naturalistic studies reviewed.

Roy-Byrne and Cowley, 1994; Younkers et al. 1998

Complete Panic Remission at Endpoint

(No panic attacks, no limited symptom attacks, CGI-I = 1 or 2)



*p < .001 (combined analysis)

Data on file, Pfizer.

The Bottom Line

Effective treatment of panic disorder is associated with

-Improved quality of life

- More appropriate health care utilization

- Decreased costs

- Increased functioning

SOCIAL PHOBIA

Man is the only animal that blushes, or needs to

Mark Twain

Social Phobia

Fear of two staring eyes is widespread throughout the animal kingdom

IM Marks, Fears Phobias and Rituals, 1988

Rhesus monkeys show specific freezing behavior on eye contact [but not no eye contact] with humans

NH Kalin, Scientific American 1994

[A man who] “through bashfulness, suspicion and timorousness, will not be seen abroad; … his hat still in his eyes, he will neither see nor be seen by his good will. He dare not come in company for fear he should be misused, disgraced, overshoot himself in gestures or speeches or be sick; he thinks every man observes him.”

-A patient of Hippocrates as recounted by Robert Burton.

Anatomy of Melancholy. 1621:272

Social Phobia (Social Anxiety Disorder)

- Marked persistent fear in social or performance situation
- Exposure to the feared situation almost invariably provokes anxiety
- Recognizes the fear is excessive or unreasonable
- Avoidance or endured with intense anxiety

DSM-IV, 1994

DSM-IV Social Phobia Characteristics

- **Embarrassment & humiliation fear**
- **Exposure -> anxiety**
- **Avoidance or escape or distress**
- **Social/occupational problems**
- **Social/public situations**

-Speaking, Eating, Writing, Voiding

Generalized and specific subtypes

Social Phobia

Examples of Situations Feared and Avoided

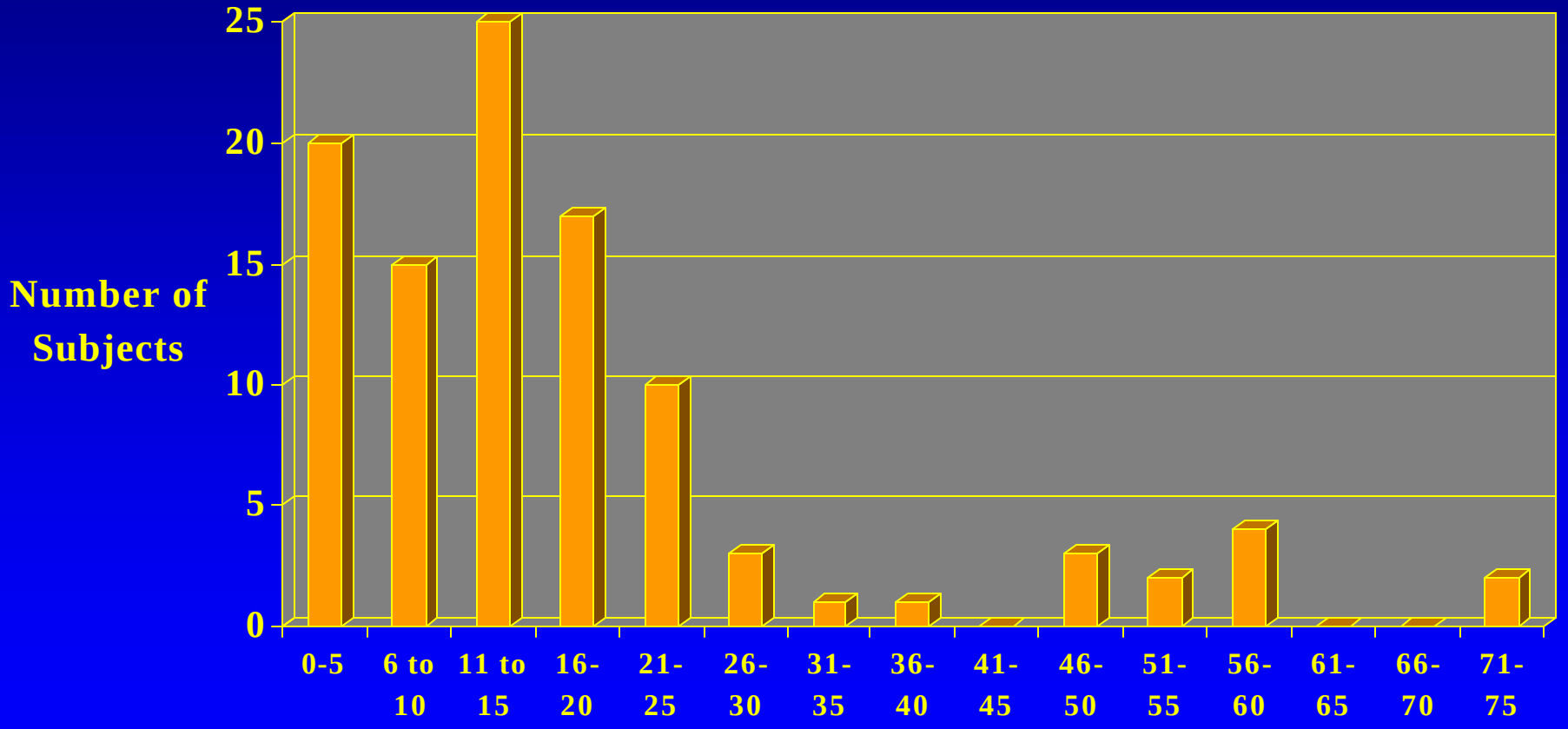
- Inability to speak in public or to strangers
- Fear of not being able to answer questions in social situations
- Fear of saying foolish things
- Inability to use public restrooms
- Inability to write in front of others
- Inability to eat in public places

Social Phobia: Epidemiology

- Prevalence*
  - 1-year prevalence: 7.9%
  - Lifetime prevalence: 13.3%
- Gender ratio
  - In epidemiological samples, 2.5:1 = F:M
  - In clinical samples, 1:1 = F:M

***National Comorbidity Survey, 1994**

Age at Onset of Social Phobia in Subjects Without Agoraphobia or Simple Phobia



n=106

Schneier et al. Arch Gen Psychiatry. 1992.

Cognitive-Behavioral Model of Social Phobia

Genetics*, hormones*, social submissive status

↓

Shyness/anxious introversion/harm avoidant style

↓

Repeated Anxiety Symptoms in Situations Involving Scrutiny by Others

↓

Anticipatory Anxiety

↓

Avoidance Behavior*

↓

Social Phobia

*F>M

* not shared with alcoholism

Social Phobia

- Median age of onset: 13 years old
- Onset after age of 25 is rare
- Chronic, unremitting, lifelong disorder
- >50% unable to complete high school
- 22.3% of pure social phobics currently on welfare
- 50% are single, divorced or separated

Judd LL, 1994

Spin

- Being embarrassed or looking stupid are among my worst fears
- Fear of embarrassment causes me to avoid doing things or speaking to people
- I avoid activities in which I am the center of attention

≥ 1 positive = 89% sensitive, 90% specific

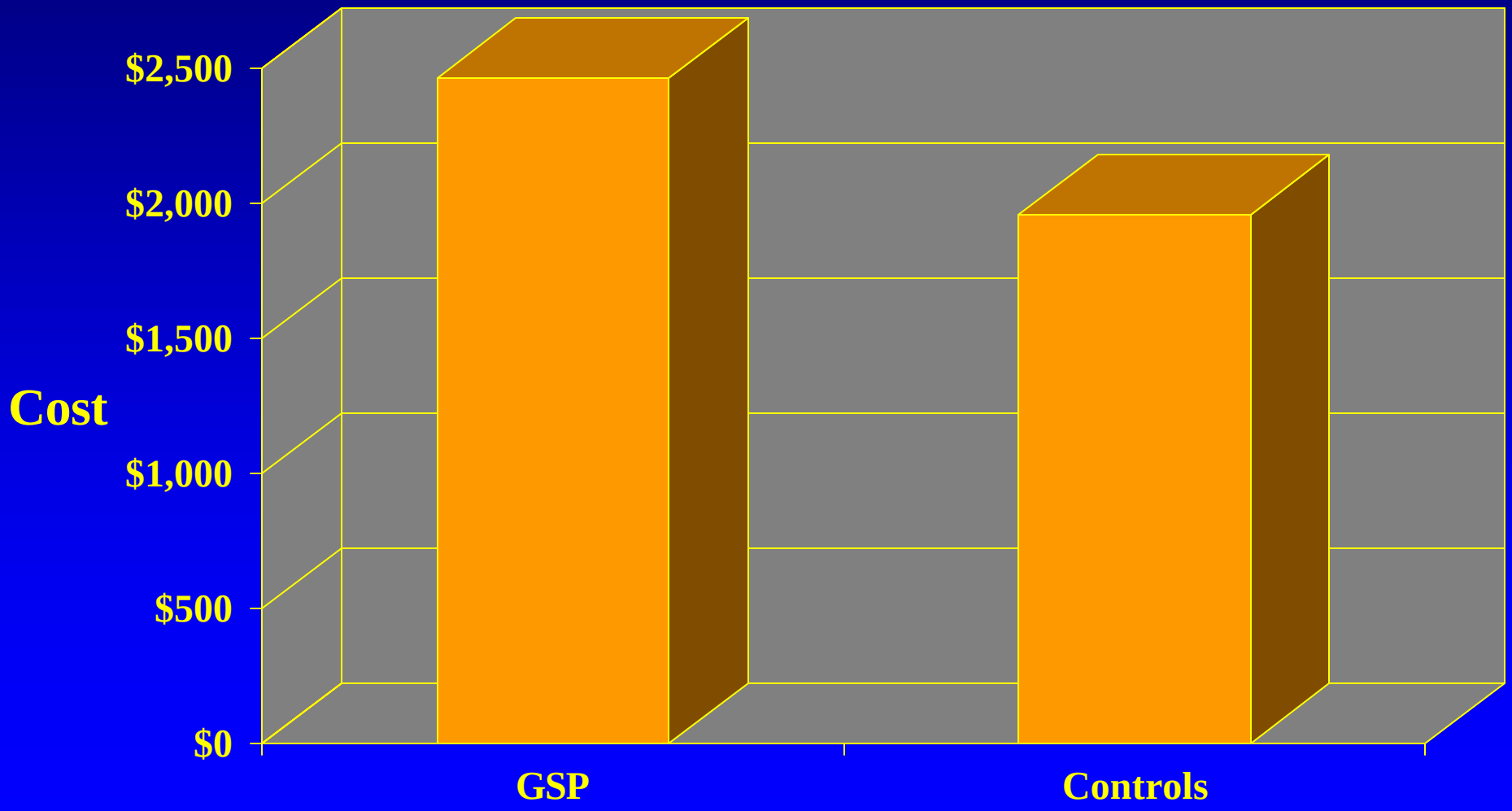
Katzelnick, 1999

Generalized Social Phobia (GSP): *Epidemiologic Burden of Illness Study*

- **N=3682 HMO members**
- **Prevalence: 8.2% by SCID**
- **Mean age 43, onset age 13**
- **0.5% diagnosed with social phobia**
- **35% had a mental health visit and/or antidepressant prescription**

Katzelnick et al. 1998

Direct Costs: *Health Care Utilization*



P=.04; difference adjusted for age and gender = $685

Work Productivity in Past Week

Generalized Social Phobia Patients: *Comorbidity Rates*

- 35.8% Depression
- 5.9% Panic Disorder
- 11.3% Alcohol abuse
- 3.4% Drug abuse
- 44.0% Any comorbidity

Social Phobia and Alcoholism: clinical issues

- Dependence and depression levels higher in AD pts with SP, though drinking intensity similar to AD pts w/o SP
- AD pts with SP drink more often to relieve anxiety than AD pts without SP: self-Rx
- Similar SP sx presentation in AD females, but more Axis I comorbidity
- Difficult to engage in AA and other groups
- CBT > 12 step facilitation in improving drinking outcomes.

Thomas et al, 1999; Thevos et al., 1999; Randall et al 2000

Social Phobia:
Self-Medication with Alcohol

"To help me overcome my shyness and make me feel more comfortable before all those personal appearances, I'd warm up with 3 or 4 vodkas before leaving the hotel, go straight to the cocktail party and have 3 or 4 more drinks…"

--Mickey Mantle

Treatment Options for Social Phobia

- Cognitive behavior therapy
- Pharmacotherapy
  - Beta-blockers: best for speaking phobia
  - MAOIs (irreversible and reversible)
  - Benzodiazepines: clonazepam
  - Buspirone
  - SSRIs: agents of choice in 2001
  - Gabapentin
  - TCAs
  - Other agents

Scholastic Aptitude Test (SAT) and Performance Anxiety (N=32)

- On retest
  - Expected improvement 14 points
  - With propranolol (40 mg) 130 points

Faigel HC. *Clin Pediatr*. July 1991

SSRIs: *Fluoxetine*

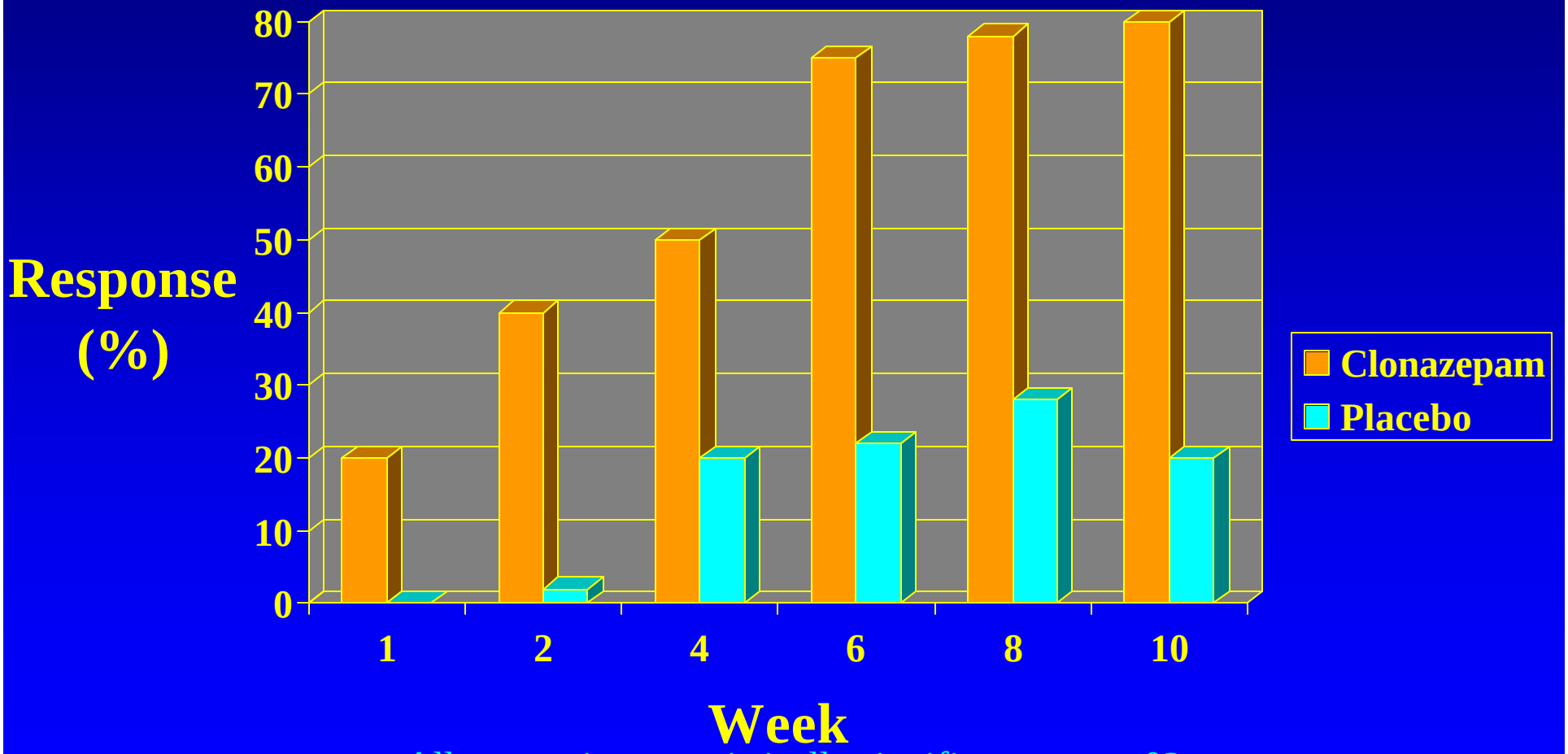
- Promising case reports

Open series	CGI = 1 or 2	Dose (mg/d)
Schneier	58%	26
Black	71%	47
Van Ameringen	77%	37 (week 8)
		54 (week 12)

- No controlled trial

Clonazepam in Social Phobia

Response Rates (n=75)



All comparisons statistically significant at $p < .02$.

Davidson JRT et al. *J Clin Psychiatry.* 1994;55:507-510

CBT for Social Phobia with or without Alcohol Dependence

- 12-week 2.5 hour sessions in groups of 6 with cognitive behavioral explanation of social phobia, cognitive restructuring skills, simulated exposure in session, in vivo homework assignments, self-administered cognitive restructuring
- Randomized Controlled Trial: CBT for alcoholism w/ and w/o emphasis on social anxiety as above for socially phobic alcoholics. Adding social anxiety CBT led to slightly worse outcomes on drinking and same effects on phobia measures.

Heimberg RG et al, 1994;
Randall et al. ACER 2001

Summary: *Social Phobia*

- Fear of embarrassment or humiliation in social situations
- Leads to distress and/or dysfunction
- Common
- Chronic
- Range of severity
- Treatable

OBSESSIVE-COMPULSIVE DISORDER [OCD]

Obsessive Compulsive Disorder

vs.

Perfectionism

or

Obsessive-Compulsive Personality Style

or

Obsessive Compulsive Personality Disorder


Fifty-seven years, and I haven't stepped on a crack yet!
WMiller

DSM-IV OCD Criteria

- **A. 1. Obsessions:**
  - **– intrusive, inappropriate, or distressing**
  - **– recurrent and persistent thoughts, impulses, or images**
  - **– not simply excessive worries about real problems**
  - **– person attempts to ignore, suppress or neutralize them**
  - **– s/he recognizes they're product of their own mind**

or

- **A. 2. Compulsions:**
  - **–repetitive behavior [handwashing, ordering, checking] or mental acts [counting, praying, silent vocalizations]**
  - **– feel driven to perform in response to obsession or rigid rules**
  - **–aimed at preventing or reducing distress or situation, but not realistically connected with what prevented or excessive**

DSM-IV OCD Criteria [cont'd]

- **B. Person recognizes at some point that obsessions or compulsions are excessive or unreasonable [except in children]**
- **C. Obsessions and compulsions cause marked distress, are time-consuming [> 1 hr/d], or significantly interfere with normal routine, occupational or academic functioning, or ususal social activity and relationships**
- **D. Content not related to another Axis I Disorder [e.g., SUD, Eating Disorder]**
- **E. Not due to medical condition or substance abuse.**

OCD: Epidemiology

- Onset bimodal: teens and mid-late 20s
- Strong genetic and neurobiological basis
- Prevalence*
  - 1-year prevalence: 3-4%
  - Lifetime prevalence: 3-4%
- Gender ratio
  - In early cases, 2.5:1 = F:M
  - In later onset cases, 1:1 = F:M

***National Comorbidity Survey, 1994; Jenicke et al., 2001**

OCD and Substance Use Disorders

- OCD probably not risk factor for SUDs
- Similar cognitive characteristics in some
- Not clearly associated with particular substance of abuse

Treatment Options for Obsessive Compulsive Disorder

- Cognitive behavior therapy
- Pharmacotherapy
  - SSRIs: agents of choice in 2001
  - Benzodiazepines: clonazepam
  - Antiepileptics
  - Atypical antipsychotics for augmentiation
  - Surgery?
  - Hallucinogens?
  - NOT TCAs [except clomipramine, an SSRI]

Summary

- Panic Disorder, social phobia, and agoraphobia are common in people with SUDs, and OCD is uncommon but serious in the substance disordered client
- Diagnosis requires careful attention the specific criteria and ruling out illnesses
- These disorders can be chronic and relapsing and consistent, early treatment can prevent disabilty
- Pharmacotherapy is effective for these disorders, as is cognitive behavioral psychotherapy

Those who are obsessed with practice, but have no science, are like a [boat's] pilot setting out with no tiller or compass, who will never know for certain where he is going.

-- Leonardo da Vinci